PAYMENT INFORMATION FORM

As Government vendors, organizations with Medicare contracts are paid by the Department of Treasury through an Electronic Funds Transfer (EFT) program. Government vendor payments are directly deposited into corporate accounts at financial institutions on the expected payment date. Additionally, CMS must have the EIN/TIN and associated name as filed with the IRS.

ORGANIZATION INFORMATION

NAME OF ORGANIZATION: _____
DBA, if any: _____

ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT PERSON NAME: _____
TELEPHONE NUMBER: _____

CONTRACT NO's.: H _____; H _____; H _____; H _____
(If known)

EMPLOYER/TAX IDENTIFICATION NUMBER (EIN or TIN): _____

A FORM 1099.MISC WILL BE MAILED TO YOU AT THIS ADDRESS:
TIN/EIN NAME: _____
STR1: _____
STR2: _____
CITY: _____
STATE: ____ ZIP: _____ - _____

FINANCIAL INSTITUTION

NAME OF BANK: _____
ADDRESS: _____
CITY: _____ STATE: ____ ZIP CODE: _____ - _____

ACH/EFT COORDINATOR NAME: _____
TELEPHONE NUMBER: _____

NINE DIGIT ROUTING TRANSIT (ABA) NUMBER: _____

DEPOSITOR ACCOUNT TITLE: _____

DEPOSITOR ACCOUNT NUMBER: _____

CIRCLE ACCOUNT TYPE: CHECKING SAVINGS (Please attach a copy of a voided check)

SIGNATURE & TITLE OF ORGANIZATION'S AUTHORIZED REPRESENTATIVE:

_____ DATE: _____
Signature Title

_____ _____
Print Name Phone Number

MEDICARE CONTRACTOR DATA

ORGANIZATION NAME:

DATE:

ORGANIZATION CONTACTS - GIVE NAMES:

PRESIDENT/CEO:
CHIEF FINANCIAL OFFICER:
SYSTEMS CONTACT PERSON:

RECORD EXCHANGE

Method/medium organization will use to send membership records (select one):*

____ ACXIOM, Inc.
_____ MDCN (Medicare Data Communications Network)
AT&T Global Network Services Dial-U
_____ Connect-Direct (Network Data Mover-NDM)
_____Other 3rd Party Vendor

Does organization want Reply Reports (Transaction Reply) in (select one):

Electronic Data_____ or Electronic Print Image format

Note: All other monthly reports are available only in Electronic Print Image Format

* CMS has a contract with ACXIOM for access to the Enrollment Database and the Group Health Plan Master file. You may purchase minimum services only. You can contact them at

ACXIOM, Inc.
9171 Oso Avenue
Chatsworth, CA 91311

Charles Johnson
1-818-715-5735

www.acxiom-med.com or

If you elect to access the CMS Data Center, please read the Plan Communications User's Guide to determine which CMS computer systems that you will need access to. Please contact the CMS regional systems access contact person to get assistance with completing the application for access to CMS's computer systems. The regional office contact person and the form to request access to CMS's computer systems are both located in the user's guide. Please request access to the CMS systems eight weeks before your plan's active date, but no sooner. Also, you must complete the forms in this section and send them to the address given in the instructions at the same time that you submit the application. Be sure to include the signature page.

ORGANIZATION AUTHORIZATION FORM

I. **ORGANIZATION IDENTIFYING INFORMATION**

Name

Contract Number(s) H _____; H _____; H _____; H

Address

Contact Person _____ Telephone # _____

II. **THIRD PARTY CONTRACTOR INFORMATION**

A. This is to authorize the contractor, as named below, to upload membership records for our organization to the CMS Data Center. YES (Please circle)

B. This is to authorize the contractor, as named below, to access the CMS Data Center to download the monthly Grouch reports for our Organization. YES (Please circle)

Name

Address

Telephone #

III. **ADDITION OR DELETION OF A Organization**

This section authorizes the addition or deletion of an Organization.

A. Addition of a NEW Organization, Contract Number H

Name

Address

Contact Person _____ Telephone #

B. Deletion of an Organization, Contract Number H

Name

Address

Contact Person _____ Telephone #

CMS Data Center (CDC) User ID

IV. **REVOCATION OF THE USE OF A THIRD PARTY CONTRACTOR**

This authorizes CMS to revoke the use of the third party contractor, as named below, for our Organization,

Contract Number H _____, Organization Contract Name

Contractor=s Name

Address

_____ _____

Authorizing Signature Printed Name Date